PRACTICE RESOURCE – NO.2
APRIL 2015

Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care

By Margaret McManus, MHS
The National Alliance to Advance Adolescent Health
Richard Molteni, MD, FAAP
American Academy of Pediatrics

Improving transition from pediatric to adult health care is a national priority, a medical home certification standard, and a meaningful use requirement for electronic health records. Health care transition encompasses increasing youth's ability to manage their own health and effectively use health services. It also involves ensuring an organized clinical process to prepare youth and families for adult-centered care, transferring youth to a new adult provider, and orienting and engaging young adults in adult care.

In 2011, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians published a clinical report on transition that represents expert opinion and consensus on practice-based implementation of transition for *all* youth, beginning early in adolescence and continuing through young adulthood.[1] These joint recommendations were subsequently translated into a set of clinical tools, called the "Six Core Elements of Health Care Transition." These tested tools have recently been updated and are available at Got Transition, the national resource center on health care transition (www.gottransition.org).

To support the delivery of recommended transition services in pediatric and adult primary and specialty care settings, Got Transition and the American Academy of Pediatrics partnered to develop this transition payment tip sheet. It begins with a summary of alternative payment methodologies followed by a listing of transition-related CPT codes and corresponding Medicare fees, effective as of 2015. A subsequent report will be released that provides a payment crosswalk for the Six Core Elements of Health Care Transition.

Innovative Transition Payment Models

In addition to knowing the appropriate CPT codes and fee-for-service (FFS) Medicare fees for pediatric-to-adult transition services, it is also important to become aware of alternative payment methodologies and to explore the feasibility of implementing these options with public and private payers to support the provision of recommended transition services. Payers are increasingly implementing alternative payment methods for medical home and care transitions (hospital to home) that replace or complement FFS methods and emphasize quality, outcomes, and cost containment. These include pay-for performance, capitation, bundled payments, shared savings arrangements, and administrative or infrastructure payments. Below is a brief overview of these payment models and how they can be applied to incentivize the delivery of transition services in both pediatric and adult settings.

1. Enhanced Fee-for-Service Payments

Fee-for-service (FFS) payments will continue to be important in supporting the delivery of recommended transition services. Reporting the appropriate CPT codes and ensuring that private and public payers are using the current associated values for each code form the foundation for appropriate payment in FFS arrangements. Many CPT codes important to transition, such as care plan oversight and telephone/internet consultations, are often not recognized by payers. Still, it is essential to code and accurately document these services. Payers could enhance FFS payments – for example, paying pediatric and adult office visit fees at 150% of Medicare rates for the year surrounding the transfer of a new patient, recognizing the added work involved in transferring and accepting patients. They could also increase fees for care plan oversight services to ensure the development and updating of the medical summary as well as of the plan of care.

2. Pay-for-Performance

Under pay-for-performance (P4P), physicians are paid based on agreed upon performance metrics for a defined population. Payers could, for example, offer pediatric practices a bonus payment for successfully transferring their patients before age 22 with complete medical records and evidence of communication with adult providers. Similarly, adult providers could receive a bonus for accepting a certain volume of new young adult patients, communicating with the referring pediatric provider, and ensuring a primary care visit is made within six months of transfer from the pediatric provider. P4P could also be structured based on improvements made or scores received on either the Current Assessment of Health Care Transition Activities (available here) or the Health Care Transition Process Measurement tool (available here).

3. Capitation

Monthly care coordination payments or capitation can provide a mechanism for reimbursing the added time involved in preparing youth and their families/caregivers for transfer to adult care, preparing the necessary transfer documents, ensuring coordination and communication between pediatric and adult care systems, and implementing outreach and follow-up strategies for new young adult patients. These monthly capitation payments could also be adjusted for patient complexity.

4. Bundled Payments

Bundled payments by definition include multiple services typically associated with an episode of care. The CPT code for transitional care management services (99495, 99496) is an example of a set of defined services provided by a physician or qualified health care professional for a patient with moderate to high complexity who is transitioning from hospital to community-based setting. These include a face-to-face visit, communication, education to support self-care, assessment of treatment and medication management, identification of community resources, referrals, and scheduling follow-up. *This code, however, does not extend to transition from pediatric to adult ambulatory health care, only from hospital to home.* Still, it would be possible to structure a bundled payment arrangement for a package of transfer services from pediatric to adult care, including an updated medical summary and emergency care plan, transition readiness assessment, plan of care, and other services listed under the CPT Transitional Care Management Services. Templates for each of these transition services are available in the Six Core Elements packages (www.gottransition.org).

5. Shared Savings

By ensuring a successful transfer from pediatric care to adult care at a cost below budgeted amounts, the resultant savings associated with reduced emergency room visits could be shared with pediatric and adult providers. This alternative payment arrangement generally follows a defined set of structural and quality standards. In the case of transition from pediatric to adult health care, a potential option would be to use the measurement tools described above under pay-for- performance.

6. Administrative or Infrastructure Payments

This payment mechanism has been used by Medicare to support adoption and meaningful use of electronic health record technology and by Medicaid to conduct administrative activities (e.g., outreach, planning, training) to implement a state's Medicaid plan. Demonstration grants and other infrastructure investment grants have been awarded to support system changes. In the case of transition, this administrative payment strategy could be considered for covering costs of customizing electronic health records to align with the recommended core elements of transition and for transition training of pediatric and adult providers, but not for direct services.

Reference

[1] American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians, Transitions Clinical Report Authoring Group. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2011;128(1):182-200.

Transition Coding and Reimbursement

Transition Related Services		100% Medicare Payment	
CPT Code	**Code Description**	**Office**	**Facility**
Office or Other Outpatient Services, New Patient			
99201	Self-limited or minor problem, 10 min	$43.70	$26.87
99202	Low to moderate severity problem, 20 min	$74.87	$50.51
99203	Moderate severity problem, 30 min	$108.54	$77.02
99204	Moderate to high severity problem, 45 min	$165.50	$130.75
99205	High severity problem, 60 min	$207.41	$169.80
Office or Other Outpatient Services, Established Patient			
99211	Minimal presenting problems, 5 min	$20.06	$9.31
99212	Self-limited or minor problem, 10 min	$43.70	$25.79
99213	Low to moderate severity problem, 15 min	$73.44	$51.58
99214	Moderate severity problem, 25 min	$107.83	$78.81
99215	Moderate to high severity problem, 40 min	$145.44	$111.77
Office or Other Outpatient Consultations[1]			
99241	New or established patient; self limited or minor problem, 15 min	$49.08	$34.03
99242	Low severity problem, 30 min	$92.06	$70.93
99243	Moderate severity problem, 45 min	$125.74	$98.87
99244	Moderate to high severity problem, 60 min	$185.92	$156.55
99245	Moderate to high severity problem, 80 min	$227.47	$194.52
Care Plan Oversight Services[2]			
99339	Individual physician supervision of a patient in home requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s), or key caregiver(s) involved in patient's care; integration of new information into medical treatment plan; or adjustment of medical therapy; within a calendar month; 15 to 29 minutes	$78.65	$78.65
99340	30 minutes or more	$109.75	$109.75
Prolonged Services			
99354	Prolonged physician or other qualified health professional services, in office or other outpatient setting, with direct contact; first hour (use in conjunction with time-based codes 90837, 99201-99205, 99241-99245, 99324-99337, 99341-99350)	$100.30	$93.14
99355	Each additional 30 min. (use in conjunction with 99354)	$97.08	$89.92
99358	Prolonged physician services without direct patient contact; first hour	$110.47	$110.47
99359	Each additional 30 min. (use in conjunction with 99358)	$52.91	$52.91
Medical Team Conference[3]			
99366	With interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by nonphysician qualified health care professional	$43.26	$42.19

99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	$56.84	$56.84
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional	$37.18	$37.18
Preventive Medicine Services			
99384	Initial comprehensive preventive medicine, new patient; ages 12-17	$144.80	$109.66
99385	Ages 18-39	$140.78	$105.25
99394	Periodic comprehensive preventive medicine, established patient; ages 12-17	$123.12	$92.51
99395	Ages 18-39	$126.27	$95.66
Counseling Risk Factor Reduction and Behavior Change Intervention[4]			
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided by a physician or other qualified health professional to an individual (separate procedure); approximately 15 minutes	$36.54	$24.72
99402	Approximately 30 minutes	$62.33	$50.51
99403	Approximately 45 minutes	$87.05	$75.59
99404	Approximately 60 minutes	$112.48	$101.02
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	$14.33	$12.54
99407	Intensive, greater than 10 minutes	$27.58	$25.79
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	$35.46	$33.67
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	$73.09	$71.20
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes	$16.45	$7.87
99412	Approximately 60 minutes	$21.81	$13.22
Health and Behavior Assessment/Intervention[5]			
96150	Health and behavior assessment provided by a physician or other qualified health professional, each 15 minutes face-to-face with the patient; initial assessment	$21.85	$21.49
96151	Re-assessment	$20.78	$20.42
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	$19.70	$19.34
96153	For a group (2 or more patients)	$4.66	$4.30
96154	For a family (with the patient present)	$19.34	$18.99
96155	For a family (without the patient present)	$22.93	$22.93
Chronic Care Management Services[6]			
99487	Complex chronic care management services, 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	$0*	$0*
99489	Each additional 30 minutes	$0*	$0*
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	$42.63	$34.82
Transitional Care Management Services[7]			
99495	Includes communication (direct contact, telephone, electronic) with patient/caregiver in 2 business days of discharge; medical decision making of at	$164.78	$111.41

	least moderate complexity during service period; and face-to-face visit, in 14 calendar days of discharge		
99496	Includes communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of high complexity during the service period; and face-to-face visit, within 7 calendar days of discharge	$232.49	$160.84
Telephone Services[8]			
99441	Telephone E/M service provided by a physician or other qualified health professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5 to 10 minutes of medical discussion	$14.33	$13.25
99442	11-20 minutes of medical discussion	$27.23	$25.79
99443	21-30 minutes of medical discussion	$40.48	$39.05
Online Medical Evaluation[9]			
99444	Online evaluation and management service provided by physician or other qualified health care professional who may report E/M services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic network	$0*	$0*
Interprofessional Telephone/Internet Consultations			
99446	Interprofessional Telephone/Internet Consultation by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health professional; 5-10 minutes of medical consultative discussion and review	$0*	$0*
99447	11-20 minutes	$0*	$0*
99448	21-30 minutes	$0*	$0*
99449	31 minutes or more	$0*	$0*
Education and Training for Patient Self-Management[10]			
98960	Education and training of patient self-management by a qualified, nonphysician healthcare professional using a standardized curriculum, face-to-face with a patient (could include caregiver/family) each 30 min; individual patient	$28.30	NA**
98961	2-4 patients	$13.61	NA**
98962	5-8 patients	$10.03	NA**
Miscellaneous Services			
99078	Educational services rendered to patients by physician or other qualified health professional in a group setting (eg, obesity or diabetic instructions)	$0*	$0*

*$0 indicates that there are no RVUs assigned to this code.

**NA indicates that established values assigned to this code are not application in certain settings.

CPT Description of Selected Codes

[1]**Office or Other Outpatient Consultations** (99241-99245) Although Medicare no longer recognizes consultation codes; most other payers still allow their use. It is important to distinguish the difference between consultations and transfer of care. A consultation is a type of E/M service provided at the request of another physician or other appropriate source for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. A physician consultant may initiative diagnostic and/or therapeutic services at the same or subsequent visit. A consultation initiative by a patient and/or family and not requested by a physician or other appropriate source is not reported using the consultation codes but may be reporting using the office visit codes as appropriate. The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. If subsequent to the completion of a consultation the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the appropriate E/M service code should be reported. *Coding Tip*: Transfer of care is the process whereby a physician who is providing management for some/all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility, and who from the initial encounter is not providing consultative services. The decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

[2]**Care Plan Oversight Services** (99339 – 99340) are reported separately from codes 99374-99380, which refer to care plan oversight services for patients under the care of a home health agency, hospice, or nursing facility. This code is for physician supervision of a patient requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including phone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decisions maker(s) (eg, legal guardian) and/or key caregiver(s) involved in a patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month.

[3]**Medical Team Conferences** (99366 – 99368) include face-to-face participation by a minimum of three qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the patient), with or without the presence of the patient, family member(s), community agencies, surrogate decision maker(s) (eg, legal guardian), and/or caregiver(s). The participants are actively involved in the development, revision, coordination, and implementation of health care service needed by the patient. Reporting participants shall have performed face-to-face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days. Physicians or other qualified health care professionals who may report E/M services should report their time spent in a team conference with the patient and/or family present using E/M codes (and time as the key controlling factor for code selection when counseling and/or coordination of care dominates the services). These introductory guidelines do not apply to services reported using E/M codes. However, the individual must be directly involved with the patient, providing face-to-face services outside of the conference visit with other physicians and qualified health care professionals or agencies. The team conference starts at the beginning of the review of an individual patient and ends at the conclusion of the review. Time related to record

keeping and report generation is not reported. The reporting participant shall be present for all time reported. The time reported is not limited to the time that the participant is communication to the other team members or patient and/or family. Time reported for medical team conferences may not be used in the determination of time for other services such as care plan oversight (99374-99380), home, domiciliary, or rest home care plan oversight (99339-99340), prolonged services (99354-99359), psychotherapy, or another E/M service. For team conferences where the patient is present for any part of the duration of the conference, nonphysician qualified health care professionals (eg, speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians) report the team conference face-to-face code 99366.

[4]**Counseling Risk Factor Reduction and Behavior Change Intervention** (99401 – 99408) are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from E/M services that may be reported separately when performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment. Preventive medicine counseling and risk factor reduction interventions will vary with age and should address such issues as family problems, diet and exercise, substance use, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter. Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Any E/M services reported on the same day must be distinct, and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up. For counseling groups of patients with symptoms of established illness, use 99078 (see Miscellaneous Services in the table above for detail).

[5]**Health and Behavior Assessment Procedures** (96150 – 96155) are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments. The focus of the intervention is to improve the patient's health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems. Codes 96150 – 96155 describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the patient's health status. These services do not represent preventive medicine counseling and risk factor reduction interventions. For patients that require psychiatric services (90785-90899) as well as health and behavior assessment/intervention (96150-96155), report the predominant service performed. Do not report 96150-96155in conjunction with 90785-90899 on the same date. E/M codes (including Counseling Risk Factor Reduction and Behavior Change Intervention [99401-99412] should not be reported on the same day.

[6]**Care Management Services** Care management services are management and support services provided by clinical staff under the direction of a physician or other qualified health professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services may include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living. A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measureable treatment goals, symptoms management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the practices will be directed/coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan. Codes 99487, 99489, 99490 are reported only once per calendar month and may only reported by the single physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month. The face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, professionals, and agencies; revising, documenting, and implementing the care plan; or teaching self-management is used in determining the care management clinical staff time for the month. Only the time of the clinical staff of the reporting professionals is counted. Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient. Do not count any clinical staff time on a day when the physician or qualified healthcare professional reports and E/M service. Care management activities performed by clinical staff typically include:

- communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- collection of health outcomes data and registry documentation;
- patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family;
- management of care transitions not reported as part of transitional care management (99495, 99496);
- ongoing review of patient's status, including review of laboratory and other studies not reported as part of an E/M service, noted above;
- development, communication, and maintenance of a comprehensive care plan.

The care management office/practice must have the following capabilities:

- provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week;

- provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- provide timely access and management for follow-up after an emergency department visit or facility discharge;
- utilize an electronic health record system so that care providers have timely access to clinical information;
- use a standardized methodology to identify patients who require care management services;
- have an internal care management process/function whereby a patient identified as meeting the requirements for the services starts receiving them in a timely manner;
- use a form and format in the medical record that is standardized within the practice;
- be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

  - **Chronic Care Management Services** (99490) is reported when at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
    - multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
    - chronic conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline;
    - comprehensive care plan established, implemented, revised, or monitored.

  - **Complex Chronic Care Management Services** (99487, 99489, 99490) has the following required elements:
    - multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
    - chronic conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline,
    - establishment or substantial revision of a comprehensive care plan,
    - moderate or high complexity medical decision making;
    - 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

[7]**Transitional Care Management Services** (99495 – 99496) are used to report transitional care management services (TCM). These services are for new or established pediatric or adult patients whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continued for the next 29 days. TCM is comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction. Non-face-to-face services, under the direction of the physician or other qualified health care professional, may include:

- communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- patient and/or family/caretaker education to support self-management, independent living, and activities of daily living
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care professional may include:

- obtaining and reviewing the discharge information (eg, discharge summary, as available, or continuity of care documents;
- reviewing need for or follow-up on pending diagnostic tests and treatments;
- interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
- education of patient, family, guardian, and/or caregiver;
- establishment or reestablishment of referrals and arranging for needed community services
- assistance in scheduling any required follow-up with community providers and services.

TCM requires a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames. The first face-to-face visit is part of the TCM service and not reported separately. Additional E/M services after the first face-to-face visit may be reported separately. TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic, or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit. These services address any needed coordination of care performed by multiple disciplines and community service agencies. The reporting individuals provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living support by providing first contact and continuous success. Medical decision making and the date of the first face-to-face visit are used to select and report the appropriate TCM code. For 99496, the face-to-face visit must occur within 7 calendar days of the date of discharge, and medical decision making must be of high complexity. For 99495, the face-to-face visit must occur within 14 calendar days of the date of discharge, and medical decision making must be of at least moderate complexity. Only one individual may report these services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent just charge (S) within the 30 days. The same individual may report hospital or observation discharge services and TCM. However, the discharge service may not constitute the required face to face visit. Same individual should not report TCM services provided in the post-operative period of a service that the individual reported. A physician or other qualified healthcare professional who reports codes 99495, 99496 may not report care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), anticoagulant management (99363, 99364), medical team conferences (99366-99368), education and training (98960-98962, 99071, 99078), telephone services (98966-98968, 99441-99443), end stage renal disease services (90951-90970), online medical evaluation services (98969-

99444), preparation of special reports (99080), analysis of data (99090, 99091), complex chronic care coordination services (99487-99489), medication therapy management services (99605-99607), during the time period covered by the transitional care management service codes.

[8] **Education and Training Services for Patient Self Management** (98960 – 98962) teach the patient (may include caregiver) how to effectively self-manage the patient's illness(s)/disease(s) or delay disease comorbidity(s) in conjunction with the patient's professional healthcare team. Education and training related to subsequent reinforcement or due to changes in the patient's condition or treatment plan are reported in the same manner as the original education and training. The type of education and training provided for the patient's clinical condition will be identified by the appropriate diagnosis code(s) reported. The qualifications of the nonphysician healthcare professionals and the content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society, nonphysician healthcare professional society/association, or other appropriate source. Education and training for patient self-management may be reported with these codes only when using a standardized curriculum. The curriculum may be modified as necessary for the clinical needs, cultural norms and health literacy of the individual patient(s).

[9] **Telephone Services** (99441 – 99443) are non-face-to-face E/M services provided by a physician or other qualified health care professional, who may report E/M services. These codes are used to report episodes of patient care initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see that patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise if the telephone call refers to an E/M service performed and reported by that individual within the previous seven days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure.

Acknowledgements

The authors gratefully acknowledge the funding support for this work from the federal Maternal and Child Health Bureau (MCHB) and the expert reviews by MCHB's Dr. Marie Mann, members of the American Academy of Pediatrics' Committees on Coding and Nomenclature and Child Health Financing, and Meg Comeau of the Catalyst Center.

Got Transition™/Center for Health Care Transition Improvement is a program of the National Alliance to Advance Adolescent Health and is funded by cooperative agreement U39MC25729 HRSA/MCHB ("Transition Services in Adolescent Health - Healthy and Ready to Work"). The authors of this practice resource are solely responsible for its contents. No statement in this practice resource should be construed as the official position of the Health Resources and Services Administration, the Maternal and Child Health Bureau, or the American Academy of Pediatrics. For more information about our work and available publications, contact our office at info@GotTransition.org. Also visit us on our website at www.GotTransitiong.org.

THE NATIONAL ALLIANCE TO ADVANCE ADOLESCENT HEALTH
1615 M Street NW, Suite 290, Washington DC 20036
p: 202.223.1500 f: 202.429.3957